Final Report

Developmental Planning Task Force

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Developmental Planning Task Force Members

Tom Crosser, Chairman	Office of Budget and Program Planning
Representative Francis Bardanouve	House of Representatives
Gail Gray	Office of Public Instruction
Richard Heard	Montana Developmental Center Boulder, Montana
Jerry Hoover	Mental Health and Residential Services Division Department of Institutions
Senator Thomas Keating	Senate
Gary Marbut	Developmental Planning and Advisory Council
Dennis Taylor	Developmental Disabilities Division Social and Rehabilitation Services
Rena Wheeler	Special Training for Exceptional People Billings, Montana

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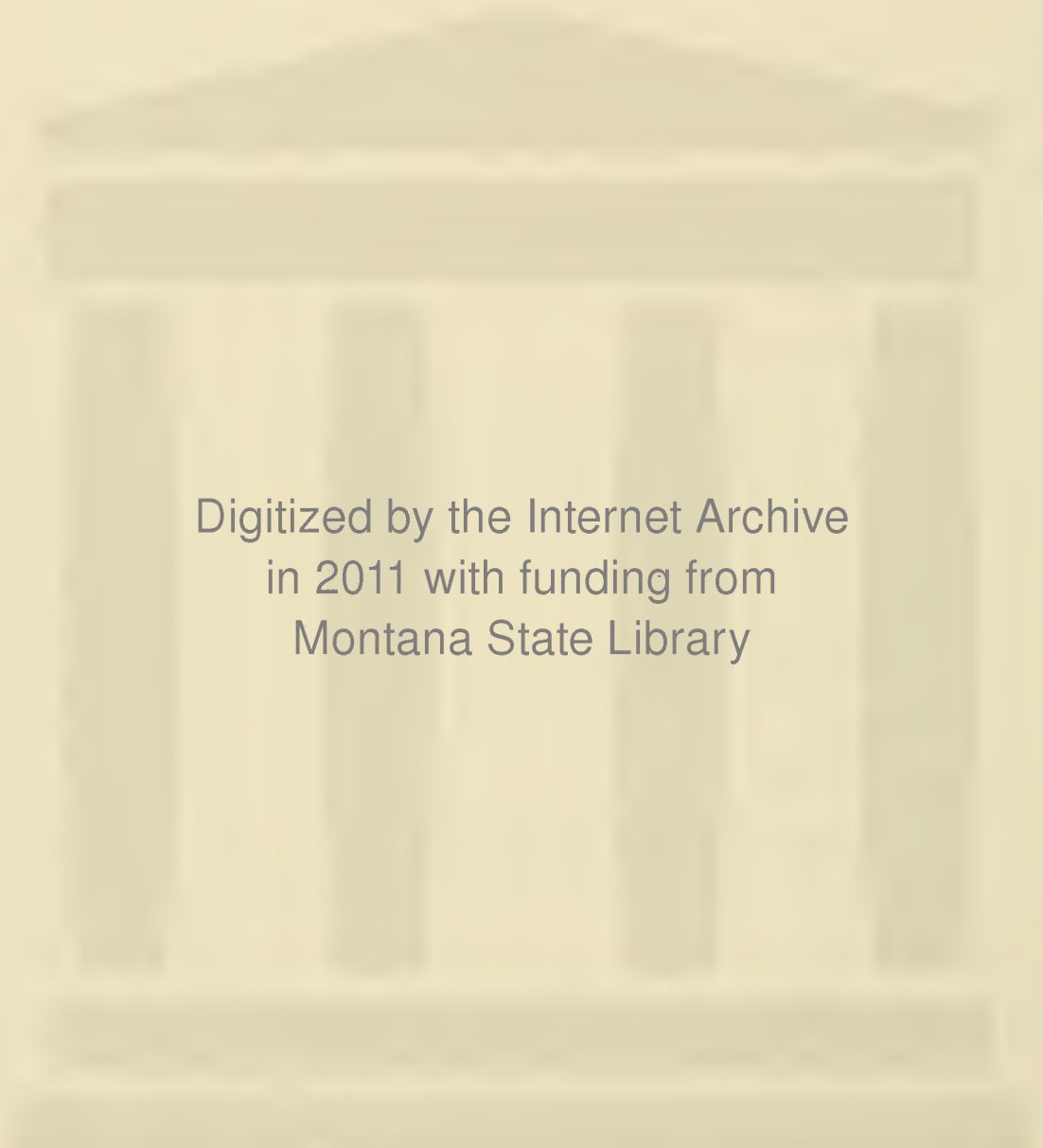

SUMMARY OF RECOMMENDATIONS

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#1 The Task Force recommends the consolidation of all services for persons with developmental disabilities under a single administrative authority. 9

#2 The Task Force recommends consideration by the Legislature of a joint resolution of support for and policy commitment to supported work services for Montana's citizens with severe disabilities. 11

#3 The Task Force recommends that programs be established to fill gaps that exist in the array of DD services. To meet the needs of Montana's unserved and underserved citizens with developmental disabilities, the following programs must be developed: 1) specialized service and support organizations, 2) supported living, 3) adult congregate living and 4) group homes. In addition, new and perfected programs must be established to serve geriatric citizens with developmental disabilities and those with intensive medical and behavioral needs. 14

The Task Force views Montana Developmental Center as an integral part of the array of services and recommends that it serve the following specific missions: 1) residential service provider for persons with severe behavior problems, 2) residential service provider for naive offenders, 3) residential service provider for persons with severe medical and/or care needs, and 4) professional resource for community-based DD service programs.

The Task Force views Eastmont Human Services Center as an integral part of the array of services and recommends that it specifically serve as an exemplary geriatric program for Montana's senior citizens with developmental disabilities.

#4 The Task Force recommends improvements in community services in the areas of case management, respite care, and staff training, and the establishment of an additional service component--independent reviews of placement and treatment. 22

#5 The Task Force recommends that the Developmental Disabilities Division of the Department of Social and Rehabilitation Services be designated as the lead agency for a new state grant program for handicapped infants and children. 25

#6 The Task Force recommends passage by the Legislature of a joint resolution supporting increased public awareness of naive offenders and the establishment of policies and procedures to identify and treat them. 26

#7 The Task Force recommends that the state expand existing services to meet the needs of all Montana's citizens with developmental disabilities. 27

Introduction

In March, 1986, the Developmental Planning Task Force was created by the Developmental Disabilities Planning and Advisory Council (DDPAC). Funded by the DDPAC, the Departments of Social and Rehabilitation Services and Institutions and the Office of Public Instruction, the Task Force was charged with two missions. Its primary mission was to provide answers to the following two questions:

- What are the needs of Montanans with developmental disabilities who are unserved and underserved?
- How can those needs best be met?

A secondary mission of the Task Force was to monitor progress toward several previously identified objectives--specifically, those which involved implementation of key recommendations made by the House Bill 909 Advisory Council.[1]

In response to legislative concern, a third investigation was also undertaken by the Task Force. That study involved evaluation of the Legislative Fiscal Analyst's recommendation to restructure the administration of services funded by the Developmental Disabilities Division.[2] Because that study was prompted by legislative request, its procedures and conclusions are reported in a separate document.

The Developmental Planning Task Force is a nine-member committee appointed by the DDPAC. Its members represent a broad spectrum of interests and backgrounds, with most possessing extensive experience in or knowlege of developmental disabilities. To provide staff support for the Task Force, the DDPAC contracted with an independent

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1 The House Bill 909 Advisory Council was created by Executive order in response to legislative mandate (2-15-122,MCA). "Key" recommendations were identified by the DDPAC and were subsequently approved by the Task Force. They are described in the portion of this report which deals with its secondary mission.

2 During the 1986 Special Legislative Session, the Joint Human Services Subcommittee of the Appropriations-Finance Committee reviewed and requested further study of a recommendation contained in the Legislative Fiscal Analyst's "Budget Analysis, Special Session III", (pg. B-86), Issue 14: Administrative Reorganization of Developmental Disabilities.

consultant. This report details the process and documents the findings of the Developmental Planning Task Force in its study of these issues.

Primary Mission

Meeting the Needs of Unserved and Underserved Montanans with Developmental Disabilities

Methodology

Planning to meet the needs of unserved and underserved Montanans with developmental disabilities required two preliminary tasks: (1) identifying those persons with a developmental disability who might be appropriately described as unserved or underserved and (2) determining their needs. After considerable discussion and deliberation, the Task Force unanimously agreed that the following groups represent the unserved and underserved:

- .persons on the community waiting list
- .certain residents of Montana Developmental Center
- .certain residents of Eastmont Human Services Center
- .certain Montana State Hospital residents with developmental disabilities
- .Nursing home residents under the age of 21 with developmental disabilities

Since Montana law specifies that persons with developmental disabilities have a right to habilitation under the least restrictive conditions (53-20-148,MCA), the underserved in some cases are individuals who currently receive service in a setting which is overly restrictive for them. In other cases, the underserved are persons receiving appropriate but insufficient service. A client might, for example, be receiving an appropriate residential service while awaiting another service such as vocational training.

Since statistical sampling procedures allow generalizations to be made from a sample to the population with accuracy, the Task Force did not assess every person identified as unserved or underserved. Using a random selection procedure, 20% of the children and adults on the waiting list and 50% of the residents of Montana

Developmental Center were selected for the study. One hundred percent of persons in the other groups were included, for a total of 402 individuals selected for inclusion in the study.

Data Collection

To determine individual needs, the Task Force elected to use the Individual Behavior Assessment (IBA) for two reasons. First, it had proved to be satisfactory when used in a joint study conducted in 1982 by the Departments of SRS and Institutions. Second, a variation of the IBA is currently used by many of Montana's service providers. In some cases, they needed only to fill out a short supplemental form to provide the necessary data.

The assessment of children under 6 years of age included an abridged version of the IBA and a Denver Developmental Screening Test. Because Child and Family Service providers expressed concern that the children's assessments might not reveal all of their needs, a supplemental form was also used with them. That inventory allowed family trainers to rate each child's need for each type of service.

Assessments of residents in state-operated institutions were completed by appropriate direct care and/or nursing staff. Area Office DDD staff assumed responsibility for data collection for persons on the community waiting list. OPI staff provided assessment data for children in nursing homes and assisted with assessments of some special education students.

Completed assessment forms were returned and assigned code numbers. All identifying information was then removed so that subsequent analyses and evaluations by Task Force members were done "blind." That is, neither client identity nor residence was known to evaluators.

A three-person subcommittee evaluated and ranked each individual on each of seven dimensions: behavioral, medical, self-care, nursing care, mobility, communication and vocational. (Refer to Appendix A for a detailed description of the rankings within each domain.) Every client was independently evaluated and ranked on every dimension by every subcommittee member. A client's overall rating in each domain resulted from subcommittee agreement which occurred when: (1) all three members gave the same rating or (2) two of three raters gave identical ratings and the third rating differed by only one point. When a discrepancy occurred (a difference in rating of two or more points), the subcommittee jointly re-evaluated that client and reached consensus.

Inter-rater reliability was very high. An analysis completed when 75% of the IBAs had been returned revealed discrepancies on less than five percent of the domains ranked. In other words, subcommittee members were able to consistently draw very similar conclusions about an unknown individual's skills and needs using only the Individual Behavior Assessment.

Client groups were created from the data by grouping individuals of similar age having similar profiles (i.e., the same scores on important domains). These groups are summarized in Table 1 and discussed under "Results."

The data collection phase of the study culminated with an information-gathering hearing at which 16 professionals and parents testified. All participants were asked to address these potential needs of each client group: program features, program location, professional services, support services, staff qualifications, staffing ratio, equipment needs, segregation by age, other service needs. Additional information about the hearing, including a list of participants, is

provided in Appendix B.*

Testimony at the hearing was the impetus for many of the subcommittee's recommendations. Those recommendations were subsequently presented to and accepted by the full Task Force and were the basis for two resolutions proposing long-term plans for provision of services to Montana's citizens with developmental disabilities. Following a description of the data and client groupings, each of these recommendations will be reviewed.

Results

A total of 402 individuals were included in the research sample; however, completed IBAs were returned for only 354 (88%) of them. Several additional IBAs (approximately ten) were returned late or incomplete and were excluded from further analysis. Only the community waiting list group was represented by less than a 100% return. One significant difference between that group and the others makes the incomplete response less surprising. Unlike the others, clients on the waiting list are typically not a "captive" group. Scattered throughout the state, they are occasionally difficult to locate and obtaining information about them often requires the voluntary participation of a relative or friend. Much time and energy went into the data collection effort and the incomplete return from the waiting list contingent in no way reflects a lack of staff cooperation.

The client groups which developed out of the subcommittee review are defined and described in Table 1 (p. 6). More detailed descriptions of each group are provided in Appendix C. It is important to note that each client is represented in only one group. An individual might qualify for two groups on the basis of rankings (e.g., Behavior 2 and Care 3), but s/he was placed only in the group

*The hearing was tape recorded in its entirety; those tapes will be presented to the DDPAC along with report and will be available upon request.

Group	Definition	Population Estimates* Children	Adults	Seniors**	Total
Medical 1/2	Life support needs (e.g., on site emergency medical help or need for oxygen, suctioning) Frequent and/or severe emergency medical needs (e.g., seizures with frequent injuries, frequent need for hospitalization)	17	23	2	42
Behavior 1	Behaviorally dangerous (e.g., behavior intensity is very high and safety of clients or property is an issue even with staff present)	8	21	2	31
Behavior 2	Serious behavior problem (e.g., behavior rate and intensity is moderately high; safety is usually not an issue if supervision present)	25	122	4	151
Care 1	Needs total care	72	51	2	125
Care 2	Extreme deficits in basic self-help skills (e.g., not toilet trained; few dressing, bathing or eating skills)	41	64	9	114
Care 3	Significant deficits in basic self-help skills (e.g., some assistance required with toileting, dressing, bathing and eating)	62	81	23	166
Care 4	Generally independent in basic self-help skills (e.g., toilet trained; minimal assistance required with dressing, bathing and eating)	163	416	45	624
Table 1. Summary of Client Groups According to Shared Characteristics.	Total	388	778	87	1253

*These numbers were rounded so some rounding error will occur.
**Children: 18 years or less; Adults: 19 - 54 years; Seniors: 55 years or more

viewed as a higher priority. Table 1 lists the seven groups in order of priority. Medical needs were viewed as the most important followed by behavior needs and care needs.

Each group is quantified in terms of a population estimate, an estimate of the number of people in the population who have similar profiles. Estimates were made on the basis of client sample size from each location. For example, 53% of the current MDC population was assessed and ranked. Therefore, for each MDC client with a particular profile, the assumption is made that there are a total of 1.9 MDC clients with that profile. The number of clients in the sample from each location and the factors used to predict population estimates are summarized in Appendix D.

Because this study was conducted as rigorous experimental research, the resulting data are, to the greatest extent possible, accurate and free from bias. Like any research project, this one has certain limitations and its results must be viewed in the context of those qualifications.

Montana's underserved and unserved citizens with developmental disabilities include individuals on the community waiting list and residents of several institutions. None of those groups remain static. The waiting list is compiled quarterly by the Developmental Disabilities Division; participants in this study were randomly selected from the December 1985 list, which included approximately 900 individuals.* That list has grown since. The data are most accurately viewed as a "snapshot" in time. This does not render the data meaningless since it is highly unlikely that any of those groups have undergone sufficient change to alter the data in any substantive way.

*The waiting list includes individuals receiving no services as well as individuals receiving certain services but awaiting others. In other words, a person on the waiting list is not necessarily unserved; she or he may be underserved.

It is possible that certain unserved persons were not represented in this study. There may be people receiving no services whose names have never appeared on the waiting list. Perhaps they have not been identified as developmentally disabled or their parents may have elected to receive no services in the foreseeable future. Other parents may have opted against placing their child's name on the waiting list because the application process for some services is extensive. There is some evidence that parents wait to apply until they believe their child will actually receive the service. Whatever the case, there may be people with developmental disabilities unknown to the Task Force at this time. Planning must occur on the basis of known quantities. The assumption is made that the heretofore unidentified person may change the number of service needs, but not their nature.

A final point must be made about the children's data. According to Child and Family Service providers who compile the children's waiting list, those lists have an inherent bias. Children with the most intense needs are routinely served first so the waiting list has a disproportionately high number of children with less intense needs. Children's needs, determined by the family trainer inventory, are summarized in Appendix E. The most frequently cited needs were for skill acquisition training, parent training and diagnosis and evaluation.

Recommendations

A number of Task Force recommendations developed in direct response to the previously mentioned client groups. For example, the modified mission of Montana Developmental Center and Eastmont Human Services Center were proposed to meet the more intense medical, behavioral, and care needs of adults and seniors, respectively. In other cases, recommendations were proposed in response to concerns expressed by

Task Force members (e.g., the need for independent review of placement and treatment) of concerns voiced at the public hearing (e.g., the need to provide services for the naive offender). The existence of the naive offender population, for example, was not revealed directly by the assessment process. The Task Force became aware of a significant number of unserved or inappropriately served individuals who fall into this category through public testimony and follow-up on assessments.

These combined recommendations represent the Task Force's proposal for the development or expansion of programs to create a service array designed to meet the needs of all of Montana's unserved and underserved. These are long-term goals, not short-term objectives. On the following pages, each of the recommendations is briefly described.

Recommendation: The Task Force recommends the consolidation of all services for persons with developmental disabilities under a single administrative authority.

Services for Montanans with developmental disabilities have historically been provided by four agencies--Social and Rehabilitation Services, the Office of Public Instruction, the Departments of Health and Environmental Sciences and Institutions. Administering institutional and community-based programs through separate agencies fosters difficulties with communication, cooperation and coordination of service delivery. At no time is this problem more evident than when resources are allocated. The budget for community DD programs is considered

by the Human Services Subcommittee while institutional budgets are reviewed by the Institutions Subcommittee. (Both are subcommittees of the Appropriations-Finance Committee.)

The recommendation to consolidate DD services in a single agency is not new. Others who have studied the DD service delivery system have reached the same conclusion. The House Bill 909 Council recommended that DD services be combined within the Developmental Disabilities Division of SRS. That study described the DD service system as "needlessly complex" and cited specific problems with confusion over lines of authority, inadequate accountability and public uncertainty about access to the system.

More recently, the SRS Disability Task Force conducted an independent study which drew similar conclusions. After a five-month investigation, that task force concluded that the creation of a distinct administrative agency for disability services had substantial merit. In a survey of other states, the task force also found considerable support for the concept of a single agency providing all administrative support for disability services.

On the basis of its limited study, the Developmental Planning Task Force cannot endorse a specific plan for the proposed consolidation. Instead, the Task Force suggests that an interim legislative committee be established to investigate and evaluate alternatives to achieve the needed consolidation.

The purpose of an administrative agency is to manage resources, support and evaluate services, provide continuity and plan for the future. It seems clear that these

tasks can more efficiently be accomplished by a single DD state agency with responsibility for community-based and institutional services.

Recommendation: The Task Force recommends consideration by the Legislature of a joint resolution of support for and policy commitment to supported work services for Montana's citizens with severe disabilities.

Definition and Overview

Supported work concepts have challenged the assumptions about the need for job readiness. Community employment of individuals with severe disabilities was once merely a distant goal, seldom realized. Preparation for employment was viewed as progress through a series of steps: day activity led to work activity and then to sheltered employment and finally to competitive employment. Unfortunately, less than 5% of adults with disabilities actually move onto the next step each year.*

In the supported work model, job readiness is not a requirement for employment. Instead, the model assumes that necessary job skills can be learned at the job site. Thus, supported employment is a type of employment, not a method of preparation. Persons with severe disabilities are employed in the same settings as persons who are not disabled. The jobs are real ones, located in the competitive marketplace, and not specifically created for individuals with disabilities. To support the worker in this integrated environment, professional staff provide on-site training, advocacy, case management and follow-up services.

An extensive body of literature has documented the beneficial effects of supported work for the employee, the employer, other taxpayers, and society in general. The national climate for supported employment initiatives is good. Funding is available from several sources within state structures and the Federal government.

*Bellamy et al, 1986.

In 1986, Montana was awarded multi-year grants from the Departments of Health and Human Services and of Education to increase employment opportunities for persons with severe disabilities. The supported employment programs in Bozeman and Billings have reported considerable success over the past few years, and in recent weeks DDD/SRS has funded similar programs in Great Falls, Helena, Kalispell, Sidney and Missoula. Further expansion is anticipated; by 1992, over 60% of a broad target group of Montana's severely disabled citizens may be competitively employed.*

Economic and other Societal Benefits

The employee with disabilities becomes a taxpayer rather than exclusively a tax consumer. Putting people to work is obviously good for Montana's economy. An expanded work force creates more disposable income, which in turn results in increased purchase of goods and services from business and industry. While the tax base is expanded, the outlay for transfer payments is diminished.

Competitive employment pays better than sheltered employment. The average annual income of individuals in sheltered workshops has been estimated to be slightly over $400; the median income of persons in supported competitive employment is significantly higher. Even when the cost of the support program is included in the equation, the cost/benefit ratio clearly favors the competitively employed individual over the person involved in sheltered work.

Nationally, less than 13% of adults with severe disabilities are employed. In Montana, over 8% of the working age population (ages 16-64) report at least one disability, and more than half of this group is unemployed. Estimates of unemployment among the state's severely disabled citizens are consistent with national figures.

*Offner, 1986.

American society has a strong work ethic. Successful employment--reflecting such factors as independence, economic security, and productivity--is often regarded as an important measure of personal adjustment and quality of life. Whether an individual is viewed as an economic liability, and thus a social nuisance, or as a contributing member of the community is largely the result of the kind of work he or she performs and the manner in which he or she performs it. Employment provides opportunities to experience certain social roles, images, and personal competencies valued by the community. The role of worker for persons with severe disabilities is just as important as it is for persons without disabilities. The employed person with disabilities then becomes an integral part of that same community. Such a personal victory is equally a societal benefit.

Impact on Service Delivery System

DD professionals and community service providers concur that a "bottleneck" exists in the vocational component of Montana's service delivery system. That bottleneck represents clients who are locked into vocational slots at a lower level than is appropriate as they await more challenging work opportunities. The clients themselves have often expressed the desire to move upward. Their failure to do so unfortunately also prevents vocational training opportunities from becoming available for other people with disabilities. The waiting list has increased in numbers as potential clients await program development.

Supported employment provides opportunities to work at real jobs while also creating vacancies which will stimulate movement through the entire system of services.

Specific Benefits to the Employer

Employers who hire disabled persons often qualify for tax credits and other financial incentives such as those provided through the Targeted Jobs Tax Credit (TJTC) program, the Job Training Partnership Act (JTPA) and the Association for Retarded Citizens On-the-Job Training (ARC-OJT) Project. The National Association of Rehabilitation Facilities has documented that persons with disabilities: 1) are competent, efficient and carry their share of the work load; 2) have good attendance records; 3) help to stabilize high turnover jobs; 4) have fewer accidents than their non-disabled colleagues (which makes them good insurance risks); 5) work well with non-disabled employees and 6) receive positive reactions from customers and clientele.

Recommendation: The Task Force recommends that programs be established to fill gaps that exist in the array of DD services. To meet the needs of Montana's unserved and underserved citizens with developmental disabilities, the following programs must be developed: 1) specialized service and support organizations, 2) supported living, 3) adult congregate living and 4) group homes. In addition, new and perfected programs must be established to serve geriatric citizens with developmental disabilities and those with intensive medical and behavioral needs.

The Task Force views Montana Developmental Center as an integral part of the array of services and recommends that it serve the following specific missions: 1) residential service provider for persons with severe behavior problems, 2) residential service provider for naive offenders, 3) residential service provider for persons with severe medical and/or care needs, and 4) professional resource for community-based DD service programs.

The Task Force views Eastmont Human Services Center as an integral part of the array of services and recommends that it specifically serve as an exemplary geriatric program for Montana's senior citizens with developmental disabilities.

Organizations for Specialized Service and Support

Population to be Served

The Task Force identified several groups of individuals who need intensive services

but do not require the structure or level of nursing care to be provided by the Montana Developmental Center in its revised capacity. Many have significant deficits in basic self-help skills (e.g., toileting, eating) and require considerable staff time to accomplish their activities of daily living. Some have serious behavior problems requiring a great deal of supervision and a high staff/client ratio. Others have frequent and/or serious medical needs, but they differ in one significant way from similarly described individuals who are viewed as appropriately served at Montana Developmental Center. That critical difference is their greater responsiveness to the environment, evidenced by their mastery of some self-help and/or communication skills.

Description of Service

Because all of these individuals have clearly demonstrated responsiveness to the environment, it is essential that they be provided with an optimal environment for learning. The design of a model program for this population must reflect their need for:

- integration into the community
- small living units capable of licensure and certification as ICFs/MR for quality assurance and funding reasons
- flexible architectural design to ensure future usefulness in some other role
- intense staff/client ratio
- well-trained staff and in-house staff development department
- adequate professional staff (e.g., occupational and physical therapy) to meet specialized needs within the organization and to act as a resource to other provider agencies
- day programs to provide skill acquisition training

It is recommended that two specialized service and support organizations be assembled and appropriate structures be developed in larger population centers where, it is presumed, there will be a greater pool of professionals from which to draw. Each organization would consist of one centrally located facility and several

satellite group homes scattered throughout the community. Provision would also be made for a day program wherein self-help, prevocational and community living training could be provided. Many aspects of the organization would vary depending upon the clientele. Persons with intensive medical problems, for example, may have unique equipment or staffing needs. Flexibility in design is a critical feature since it allows an organization to alter its mission to meet changing needs in the population.

Perhaps the most distinguishing feature of these organizations is their mandate to share their professional resources with other service providers who need them. Adequate funding for professional staff and staff development must be allocated if they are to fill the role of resource.

Montana Developmental Center: Revised Mission

Populations to be Served

Persons with intensive medical or behavioral needs who require long-term care in a specially-equipped, highly-structured and intensely staffed residential setting would be appropriately served at Montana Developmental Center. Individuals with intensive medical or care needs are those with life support needs, frequent or serious medical needs or a requirement for total care. Most of these people require specialized services (e.g., physical therapy), special equipment (e.g., oxygen), and some require a nurse on site.

Individuals with intensive behavioral needs are those who present a danger to themselves or others. Using the Task Force's classification system, these are the "behaviorally dangerous" and a subgroup of those with "serious behavior problems"--specifically, those whose behavior problems cannot be adequately or easily met in the community because of seriously destructive and/or assaultive behavior. Persons identified as naive offenders are also viewed as having intensive behavior needs and would be appropriately served in this setting.

Discussion

The facility at Boulder has unfortunately been viewed historically as a repository for the developmentally disabled-- a residential alternative for anyone who, for whatever reason, could not be or, was not being provided services in the community. To move away from this outmoded concept, the Montana Developmental Center must be charged with a specific mission. Providing services to those with intensive medical or behavioral needs will be that mission. Although those two groups can be served on the same campus, under one administration, this proposal is for the development of two distinct and separate programs.

In addition to providing services for the groups previously described, it is recommended that the Montana Developmental Center act as a professional resource for other providers. Many community DD service providers have difficulty securing the professional help their clients need. With adequate funding, the professional staff at Montana Developmental Center could share its expertise with community programs.

In conjunction with this plan, those parts of the physical plant adaptable to the new missions should be renovated as necessary; those remaining should be disposed of or used for another purpose. Reduced operational expenses for the streamlined physical plant should result in a cost savings.

Eastmont Human Services Center: Revised Mission

Population to be Served

The U.S. population is aging. Americans, whether or not they are developmentally disabled, are living longer, and there is an increasingly urgent need to address the issue of providing appropriate services for them. Elderly developmentally

disabled individuals experience the same kinds of physical and mental problems that lead other elderly citizens to nursing homes; Montana is in need of appropriate facilities for them. Through the assessment process, the Task Force became aware of a significant number of elderly individuals with developmental disabilities; that number would have been much greater if developmentally disabled nursing home residents over 21 years of age had been included in this study.

Description

The design of an exemplary geriatric program must reflect consideration of the following needs of an aging population:

1. Increased health problems and medical needs
   .availability and accessibility of appropriate services
   .necessity for regular screening for health-related problems
   .dietary changes and restrictions
   .access to professional services (e.g., physical and occupational therapy)

2. Employment alternatives
   .availability of employment for the individual who wants to continue working
   .a retirement option for the individual who chooses not to work

3. Increased need for recreational and leisure activities
   .availability of age-appropriate materials and activities
   .physical aids and adaptive equipment to enable involvement

4. Increased communication and behavior problems often associated with aging
   .well-trained staff with specific knowledge of aging and DD
   .communication aids

Since 40 of the 55 beds at Eastmont are in a facility which was designed as a nursing home, the conversion of that facility into a geriatric unit would require few, if any, modifications. With sufficient staff, Eastmont could make its professional resources available to other community-based service providers.

This facility will be designed to meet the needs of those senior citizens with more intensive medical and/or behavioral needs. There is also a need for more group homes and day programs for senior citizens with developmental disabilities who do not have intensive needs.

Supported Living

Discussion

The DD system presently supports two types of residential programs for the more independent client with a developmental disability--transitional living services and independent living training. Transitional living provides an intermediate step between group home and independent living. Clients live in congregate apartments with a staff person living in the same complex to provide needed supervision for client-directed cooking, shopping and cleaning.

Independent living training provides support services to enable clients to live in their own apartments. Staff do not live on site but visit clients as needed to provide training in independent living skills such as menu planning and money management. The goal of this service is to prepare clients to live independently in the community.

These programs do not accomodate the client who neither requires a congregate living arrangement nor is expected to ever live totally independently. This individual does not require independent living training but independent living support. That support may be needed weekly, monthly or even annually depending on the client's skill repertoire and ability to manage the unpredictable and potentially stressful events of everyday life. With a paid coordinator, it is possible that this service could be provided by a volunteer effort.

Adult Congregate Living

Discussion

Adult congregate living refers to a community residential alternative for adults with developmental disabilities. Alternative residential options are needed to meet the changing needs of this population.

As societal attitudes toward institutionalization changed, more children with developmental disabilities remained in natural or foster homes. Specialized Family Care (SFC) developed to meet the habilitative, medical and support needs of these children and their families. The first of the children to benefit from SFC are now entering adulthood. The child and family who are receiving services and support one day are literally ineligible for that service the next day. Parents who worked hard to avoid institutionalization are very reluctant to accept it as a residential alternative at this point. Other solutions must be available.

In some cases, group homes offering an appropriate level of care may provide an appropriate residence for the young adult. If, however, the family arrangement appears beneficial to all, there may be no compelling reason to move the young adult out of the natural or foster home. Continued provision of service and support to the family may enable them to care for the young adult at home. Adult congregate living, then, involves providing the services and support necessary for biological or foster families to care for adults with disabilities at home.

Specialized Family Care has demonstrated that children and adolescents with developmental disabilities can be cared for in the home. Montana law requires that services be provided in the least restrictive environment. That commitment must be extended to include those people who have, literally or chronologically, outgrown the current service system.

Group Homes

Discussion

Group homes provide a community residential alternative for adults and children with developmental disabilities who do not possess the skills to live alone.

Typically, eight-bed homes have two live-in staff to provide training in self-help, community living and leisure skills. Specific service goals and staffing patterns reflect the unique needs of the particular clientele. For example, skill acquisition training, a critical component of children's group homes, is not a major concern in senior group homes where leisure and social activities are emphasized. Intensive training homes, which serve adults and children having significant behavior problems or few self-help skills,differ from the "typical" group home insofar as they provide more intensive client training and a higher staff/client ratio.

The number of group homes in Montana is not sufficient to serve the citizens who need them. One component of the recommendation for specialized service and support organizations is the construction of dispersed group homes. These will serve some of those awaiting community residences but not all of them. In accordance with the statutory mandate that citizens with developmental disabilities be served in the least restrictive environment, it is imperative that group homes, and appropriate day programs, be available to all who need them.

It is recommended that these new homes be designed to reflect state-of-the-art models. Consideration should be given to construction of homes which are smaller, accessible and more intensely staffed. A review of the literature and survey of practices in other states should be conducted to obtain information about trends, innovations and advancements in this area. In every case, appropriate day services must be provided in conjunction with the group homes.

Recommendation: The Task Force recommends improvements in community services in the areas of case management, respite care, and staff training, and the establishment of an additional service component--independent reviews of placement and treatment.

Case Management and Case Coordination Services

In simplest terms, case management involves identifying clients with developmental disabilities, assessing their strengths, deficits and overall needs, matching those individuals with appropriate services and monitoring the delivery of those services. Case management for the DD community service system is currently provided by the Community Services Division of SRS through county-based social workers. Most case managers do not have as their exclusive, or even primary, focus the individuals on their caseload with developmental disabilities. Overextended in general and under-trained in the area of DD in particular, social workers are not equipped to identify, develop and coordinate resources to meet the needs of their clients with developmental disabilities.

The Task Force favors an expanded and enhanced role for case managers with the ability to specialize in developmental disabilities. Because case managers must have an equal awareness of resources and understanding of developmental disabilities, case management services should be provided by the agency which also provides DD services, but performed independently of the contract monitoring function.

Respite Care

Respite care is the occasional and temporary provision of care to individuals with disabilities for short periods of time outside the home and away from parents or guardian. The purpose of respite care is to reduce stress for the parent or foster parent by temporarily relieving them of caretaker duties.

Montana's respite care program may be greatly enhanced if services were coordinated by a case manager and if those services, and the associated costs, were stratified

based on the client's level of disability and the perceived level of family stress. In other words, individuals with more severe handicapping conditions living in families with "higher stress" would be allocated more respite monies.

The present respite system is limited by the availability of qualified respite workers and the annual financial allocation. Currently, an allotment of $360 per year per client is made regardless of the family's need for relief or the client's handicap. There is a serious shortage of providers qualified to offer respite care, particularly to the more severely handicapped population, and it is very difficult to motivate providers to obtain additional training and become qualified when the reimbursement rate is so low.

A multi-tier system with costs based on a combination of level of disability and level of family stress will increase the reimbursement rate and provide an incentive for respite providers to receive the additional training needed to adequately serve the more difficult client. A case manager, familiar with the needs of the client, the respite resources available and the stratification system, can best serve the function of matching client with appropriate respite provider.

Staff Training

The quality of services provided by Montana's service system for citizens with developmental disabilities is dependent, to a great extent, upon its staff. Having a very well planned system of services means little if the system lacks qualified professionals and paraprofessionals to staff it.

One serious deficiency with the current system is a general lack of professional staff especially in the areas of occupational therapy, physical therapy, speech therapy and nutrition. There are few incentives to attract and keep these kinds

of professionals--one of the most obvious being wage parity with similarly trained individuals holding essentially equivalent occupational positions.

The DD service system is one which largely depends on paraprofessional staff to carry out sophisticated assignments to provide the necessary care and training for the clients they serve. To ensure an adequate pool of qualified paraprofessionals requires commitment to continuing staff training and career development as well as competitive wages.

The Task Force recommends that all state and provider agencies involved with the provision of services to citizens with developmental disabilities, including the Office of Public Instruction and the Departments of Institutions and Social and Rehabilitation Services, prepare a plan for employing more qualified persons. The Task Force urges agencies to evaluate a wide variety of alternatives to achieve this end. For example, each agency should review spending priorities to ensure that they reflect a financial commitment to staff training and career development. A requirement for certification in various areas such as CPR, medications training and client training through the Developmental Disabilities Client Programming Technician curriculum, should be evaluated. An examination of recruitment and hiring practices should be undertaken with consideration given to increasing minimal job qualifications. Toward this end, agencies might explore the idea of pre-service training provided through vocational-technical schools.

Agencies might study the feasibility of creating programs specificially designed to attract professionals. Service providers, for example, might consider awarding "scholarships" to college students in a particular field (e.g., occupational therapy) in return for the student's commitment to work for the provider for a specified time after graduation.

Resource sharing could be evaluated as a means of maximizing limited resources. With adequate funding for professional staff and staff trainers, certain agencies could share their training resources with other service providers who needed them. It has, for example, been proposed that the specialized service and support organizations and the revised programs at Montana Developmental Center and Eastmont Human Services Center be designed and funded to serve as regional resources.

Independent Reviews of Placement and Treatment

A major step toward quality assurance in the DD community service system was taken last fall when the ACMRDD standards were adopted by rule by SRS. The Developmental Disabilities Division expects all service providers to be in compliance with those standards by 1990.

While accreditation of Montana's DD providers is an important element of quality assurance, it alone is not sufficient. It it therefore recommended that the Board of Visitors extend their review to the community DD system, not necessarily by providing periodic on-site evaluations, but rather by routinely reviewing and approving all individual client training programs involving aversive and/or deprivation procedures for ethical and behavioral propriety.

Another valuable function for the Board of Visitors would be the random review of a small percentage of client placements to evaluate the appropriateness of each in meeting the client's needs.

Recommendation: The Task Force recommends that the Developmental Disabilities Division of the Department of Social and Rehabilitation Services be designated as the lead agency for a new state grant program for handicapped infants and children.

P.L. 99-457 has established a new federal early intervention program for

handicapped children from birth through two years of age. The program will be funded by the Department of Education. The legislation defines the eligible population as all children from birth through two years of age who are developmentally delayed (criteria to be determined by each state), or with conditions that typically result in delay, or (at state discretion) at risk of substantial developmental delay.

Each eligible child must receive a multidisciplinary assessment and a written Individualized Family Service Plan (IFSP), developed by a multidisciplinary team which includes the parents. This plan is similar in content to an Individual Education Plan developed by schools or an Individual Habilitation Plan developed by the Individual Planning Team.

Services for this population have historically been provided through the Developmental Disabilities Division. It seems efficacious, both programmatically and fiscally, to expand one program rather than initiate a new one with the same objectives.

Recommendation: The Task Force recommends passage by the Legislature of a joint resolution supporting increased public awareness of naive offenders and the establishment of policies and procedures to identify and treat them.

The term "naive offender" is relatively new. It refers to citizens with developmental disabilities who come into contact with the criminal justice system because they have disobeyed a law. The need to make special provision for the naive offender results from that individual's limited capacity to understand his or her criminal behavior because of intellectual impairment. Persons with developmental disabilities are also unlikely to possess the skills they would need to successfully advocate for themselves.

During the past year, the Developmental Disabilities and Planning Council and the

Attorney General's Office jointly funded a study of the naive offender in Montana. The study's purpose was the development of manuals to be used by law enforcement officers, attorneys and judges to help them recognize the naive offender. The resulting instructional materials not only prepare people to identify an offender as developmentally disabled, but they also reiterate the basic rights that all persons with developmental disabilities have.

Production of these materials was an important first step. The next step involves incorporating these or similar materials into the existing curricula of the Law Enforcement Academy, the University of Montana Law School and the Judicial School which is used for training Justices of the Peace.

Finally, there is a need to acquaint citizens who are developmentally disabled with the criminal justice system. Information about that system should be included in special education and training provided by DD service providers.

Recommendation: The Task Force recommends that the state expand existing services to meet the needs of all Montana's citizens with developmental disabilities.

Most of the preceding recommendations propose programs or services to meet the specific needs of groups identified by the Task Force. While doing much to fill gaps in the array of services, those recommendations alone are not enough to ensure that each person who needs services will receive them. Current services effectively meet the needs of the clients they serve, but they are not available in adequate numbers.

The Developmental Disabilities Division has contracted for the development of a computerized client tracking and information system. The Task Force endorses use

of that system for identifying needs and planning to meet them. The Task Force further recommends that the client tracking system form the basis for communication from the DD Division concerning progress made toward meeting the needs of all unserved and underserved Montanans with developmental disabilities.

Secondary Mission

A secondary mission of the Task Force was to monitor implementation of key recommendations of the HB909 Advisory Council. Five key recommendations were identified by the DDPAC and approved by the Task Force at its initial meeting. Table 2 (p. 29) summarizes the status of each recommendation.

The purpose of monitoring was to (1) track the success of responsible agencies in meeting projected timelines and (2) identify obstacles to implementation. If obstacles to progress appeared to be related to issues of inertia or "turfdom," the Task Force was prepared to intercede. This was not necessary.

Recommendation	Agency	Status
4.2.1.-4.2.3: Design and implement a client assessment and information system	DDD/SRS	A contract, jointly funded by DDD and DDPAC, was awarded to Human Resources Systems (contact: Dr. Robert Bruininks, Minneapolis MN) for development of a client tracking system used by several other states, the Inventory for Client and Agency Planning (ICAP). Equipment was purchased and is on site. In January, field testing will begin in Great Falls and Helena. All clients receiving services through the DD system (approximately 2000 persons) will be entered by July, 1987. At that time, plans will be made to include those individuals on the waiting list and institutional residents with developmental disabilities. Dialogue between DDD and OPI has begun with the objective of finding ways to ensure that the system will be mutually beneficial.
4.1.1.-4.1.3.: Pursue accreditation with ACDD* Review success of standards as appropriate	DDD/SRS	Sixteen provider corporations were surveyed during 1986; the remainder will be surveyed by July, 1986. To date, two corporations have been fully accredited. DDD is working to improve its IHP process to make it more congruent with the standards. It is expected that all providers will be in compliance with ACDD standards by 1990.
4.4.1.-4.4.2: Establish a task force to design a model policy for reimbursement	DDD/SRS	A fee for service reimbursement policy has been incorporated into the DD Division's contracts with seven MARF facilities. This is viewed as a pilot project and an evaluative mechanism is in place. Expansion of the fee for service model to other corporations hinges upon its success. After 6 months, both providers and DDD staff view the policy as mutually beneficial and are "guardedly optimistic" about its broader application.
2.3.1.-2.3.4: Improve planning, communication, cooperation between/among agencies through participation in IAPF	DD/PAC	According to its coordinator, IAPF is serving as a very beneficial forum for informal information exchange. The Task Force sent a letter to IAPF participants to applaud their efforts at improved communication (see Appendix F).
* 4.3.2.: Provide job descriptions for case managers	CSD/SRS	The DD Case Manager position was drafted (see Appendix G) and its use is suggested, though not mandated, by Community Services Division(CSD). CSD has no plans to specify qualifications for DD case managers which differ from other case managers. All case manager positions follow the general class specifications for Social Workers 1, 2 and 3. There is no plan to deviate from the specifications by establishing different qualifications for DD case managers.

Table 2. Status Summary of Key Recommendations.

*The Accreditation Council on Services for People with Developmental Disabilities has changed its acronym from ACMRDD to ACDD, but the name of the Council has not changed.

**Numbered objectives were excerpted from the "Redbook", A Plan for Services to the Developmentally Disabled Prepared Pursuant to HB909.

DIMENSIONS FOR RESIDENT NEEDS ASSESSMENT

Behavior Problems

1. Behaviorally Dangerous

   a. Intensity is extremely high and safety of the client, other clients, staff or property is a real issue even with staff present.
   b. Environment must be secure. Access to the community is risky even with staff present.
   c. Need the most sophisticated, well-supervised staff available. (Behavioral technology)
   d. Property damage requires major environmental or staff modification or frequent major repair.

2. Serious Behavior Problem

   a. Rate and/or intensity is moderately high and constitutes serious management problems.
   b. In general, the safety of the client or the other clients is not an issue with immediate supervision present.
   c. An intense staff-to-client ratio will take care of the problem of making the environment secure.
   d. Staff well-trained and well-supervised.
   e. Property damage a significant problem but major environmental modifications not required.

3. Significant Behavior Problem

   a. Rate and intensity is relatively low.
   b. Problems must be addressed, but do not require an intense staff-to-client ratio.

4. Insignificant or No Behavior Problem

   a. No problem behaviors recorded.
   b. Behaviors are irritating but not significant enough to be addressed in a formal way.

Care Required

1. Needs Total Care

2. Extreme deficits in basic self-help skills.

   a. Not toilet trained.
   b. Few dressing skills, bathing skills, eating skills.
   c. Considerable staff time required to get through daily routine.

3. Significant deficits in basic self-help skills.

   a. Some assistance required when toileting (prompts).
   b. Requires some assistance in dressing, bathing, eating.
   c. Staff must be present to get through daily routine (prompts/assists).

4. Generally independent in basic self-help skills.

   a. Toilet trained (Few accidents, generally independent).
   b. Minimal assistance required with dressing, bathing, eating.
   c. Staff generally spend a small amount or none of their time in physically assisting the client.

Medical Needs

1. Life Support Needs

   a. On site emergency medical help required.
   b. Examples: oxygen, suction, medication to terminate seizures.

2. Frequent and/or severe emergency medical needs.

   a. Immediate medication adjustment.
   b. Seizures, frequent injuries.
   c. Requires frequent hospitalization (4 times or 10 days total)

3. Chronic non-severe medical needs.

   a. Frequent medical problems not requiring emergency care of hospitalization.
   b. Ongoing medication use not requiring immediate modification.

4. Routine or no medical needs.

Nursing Needs

1. Nurse required on site

2. Certified staff required on site with nurse available on call as needed

3. No certified staff required

Mobility

1. Nonmobile (Totally dependent upon others for movement)
2. Nonfunctional use of wheelchair (No purposeful movement)
3. Functional use of wheelchair
4. Ambulatory with aids (May require assistance with stairs)
5. Functionally ambulatory

Communications

1. None	1. None
2. Says simple words	2. Understands simple words
3. Communicates simple needs	3. Follows simple commands
4. Communicates in phrases	4. Follows complex commands
5. Communicates complex information (Expressive)	5. Understands most conversation (Receptive)

Need for Specialized Services

Occupational Therapy
Physical Therapy
Speech
Counseling
Other as specified

Vocational Needs

1. Basic work skills or work activity (Requires almost constant supervision, tasks not necessarily "vocational" in nature)

2. Supported work or sheltered workshop (Requires intense supervision and training for a short period of time and then works at vocational task with only periodic supervision from specially trained staff)

3. Competitive Employment (Requires no supervision from specially trained staff)

L. Leisure (Retirement at 55 years or older)

Appendix B

Developmental Planning Task Force Hearing
October 8, 1986
State Capitol, Room 104

8:30	Welcome Tom Crosser, Chairman Developmental Planning Task Force
8:40	Jim Deming, Supervisor Extended Care Unit Montana State Hospital
9:00	Mike Hanshew, Administrative Officer Developmental Disabilities Division Social and Rehabilitation Services, Helena
9:20	Dawn DeWolf, Representative Montana Association of Rehabilitation Facilities
9:40	Rose Skoog, Executive Director Montana Health Care Association
10:00	Bob Visscher, Director Counterpoint, Provider program recently accredited using ACMRDD standards
10:20	Margaret Keating, Nursing Director Montana Developmental Center Boulder
10:40	Dr. Gilbert Preston, Medical Director Montana Developmental Center Boulder
11:00	Diane Sevasten, President Montana Association of Independent Disability Services
11:20	Mike Hagen, Director Montana Center for Handicapped Children Billings
11:40	LUNCH
1:00	Rick Offner, Director Montana University Affiliated Program Missoula
1:20	Jim Reynolds, Attorney Client Assistance Program Montana Advocacy Program

1:40 Elected Representative
Regional Developmental Disabilities Advisory Councils

2:00 Nona Chambers, Social Worker with specialty in Geriatrics and Developmental Disabilities
Montana State Hospital

2:20 Ron Borgman, Administrator
Stillwater Convalescent Home
Columbus

2:40 Maggie Bullock, Administrator
Vocational Rehabilitation
Social and Rehabilitation Services, Helena

3:00 Wally Melcher, Director
Region II Child and Family Services
Great Falls

Developmental Planning Task Force Hearing
Participant Discussion Issues

Please be specific as you address these issues.

1. Program Features
2. Program locations
3. Professional services (medical, psychological, occupational therapy,etc.)
4. Support services (food preparation, etc.)
5. Staff qualifications
6. Staffing ratio
7. Equipment needs
8. Segregation by age
9. Other service needs

#1: Medical Group (n = 14)*

Individuals in this group were ranked as having level 1 or level 2 medical needs according to these definitions:

Level 1: Life Support Needs
- a. On site emergency medical help required
- b. Examples: oxygen, suction, medication to terminate seizure

Level 2: Frequent and/or Severe Medical Needs
- a. Immediate medication adjustment
- b. Seizures, frequent injuries
- c. Requires frequent hospitalization

Other Characteristics:

Age Distribution	Current Location***	Specialized Service Needs**	Other Needs
0-19: 1	MDC: 12	Occupational Therapy: 13	Wheelchair: 7
20-29: 4	EHSC: 1	Physical Therapy: 3	Ambulation aids: 1
30-39: 6	NH: 1	Speech Therapy: 3	Eating aids: 3
40-49: 2			Special chair: 3
50-59: 1			Gastronomy: 1
			Oxygen: 5
			Nurse on site: 2

#2: Behavior Group 1 (n = 14)

Individuals in this group were ranked as having level 1 behavior problems according to this definition:

Level 1: Behaviorally Dangerous
- a. Intensity of behavior is extremely high and safety of the client, other clients, staff or property is a real issue even with staff present.
- b. Environment must be secure. Access to the community is risky even with staff present.
- c. Need the most sophisticated, well-supervised staff available.
- d. Property damage requires major environmental or staff modification or frequent major repair.

Other Characteristics:

Age Distribution:	Current Location	Specialized Service Needs	Other Needs
20-29: 5	MDC: 10	Occupational Therapy: 8	Oxygen: 3
30-39: 7	MSH: 4	Speech Therapy: 5	Communication aid: 1
40-49: 0		Counseling: 4	Glucometer: 1
50-59: 1			Nurse on site: 1
60-69: 1			Prader-Willi: 1

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*This is the number of adults in the research sample in this group. Others with similar needs are estimated in number using population estimates (see Table I).

**This reflects the need for professional evaluation which may or may not reveal further service needs.

***KEY: AC: Adult on community waiting list NH: Nursing Home SE: Special Ed. student on community waiting list
MDC: MT Developmental Center EHSC: Eastmont Human Services Center MSH: MT State Hospital

#3: Behavior Group 2 (n = 59)

Individuals in this group were ranked as having level 2 behavior problems according to this definition:
Level 2: Serious Behavior Problem
a. Rate and/or intensity is moderately high and constitutes serious management problem.
b. Safety of the client or others generally not an issue with immediate supervision present.
c. An intense staff-to-client ratio will take care of the problem of making the environment secure.
d. Property damage a significant problem but major environmental modifications not required.

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-19: 2	MDC: 34	Occupational Therapy: 22	Wheelchair:1
20-29: 15	MSH: 8	Physical Therapy: 2	Hearing/Visual Impairment: 17
30-39: 23	EHSC: 9	Speech Therapy: 13	Prader-Willi: 1
40-49: 11	SE: 1	Counseling: 14	Oxygen: 3
50-59: 5	AC: 7		Ambulation aids: 5
60-69: 2			Eating aids: 5
			Head protective device: 2
			Special bed: 1

#4: Care Level 1 (n = 25)

Individuals in this group were ranked as having level 1 care needs according to this definition:
Level 1: Needs Total Care

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-19: 2	MDC: 16	Occupational Therapy: 25	Wheelchair: 21
20-29: 13	MSH: 2	Speech Therapy: 5	Hearing/Visual Impairment: 15
30-39: 6	EHSC: 4		Oxygen: 2
40-49: 2	NH: 1		Special chair: 9
70-79: 2	SE: 2		Ambulation aids: 3
			Head protective device: 2
			Eating aid: 2
			Special bed: 2
			Feeding tube: 1
			Nurse on site: 1

#5: Care Level 2 (n = 34)

Individuals in this group were ranked as having level 2 care needs according to this definition:
Level 2: Extreme deficits in basic self-help skills
a. Not toilet trained
b. Few dressing, bathing, eating skills
c. Considerable staff time required to get through daily routine

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-19: 2	MDC: 10	Occupational Therapy: 30	Wheelchair: 15
20-29: 11	MSH: 5	Speech Therapy: 5	Hearing/Visual Impairment: 19
30-39: 9	EHSC: 14	Physical Therapy: 3	Oxygen: 2
40-49: 3	SE: 3 *		Special chair: 1
50-59: 5	AC: 2		Colostomy: 1
60-69: 1			Special bed: 2
70-79: 3			Ambulation aids: 5
			Eating aids: 9
			Communication aids: 2
			Head protective device: 1

#6: Care Level 3 (n = 38)

Individuals in this group were ranked as having level 3 care needs according to this definition:
Level 3: Significant deficits in basic self-help skills
a. Some assistance required when toileting (prompts)
b. Requires some assistance in dressing, bathing, eating
c. Staff must be present to get through daily routine

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs:
0-19: 2	MDC: 9	Occupational Therapy: 20	Hearing/Visual Impairment: 15
20-29: 9	MSH: 1	Physical Therapy: 1	Wheelchair: 6
30-39: 14	EHSC: 16	Speech Therapy: 11	Head protective device: 4
40-49: 5	SE: 2		Oxygen: 1
50-59: 5	AC: 9		Ambulation aids: 4
60-69: 3	NH: 1		Special bed: 1

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*In several cases, an individual could be classified as either "special education" or "adult community." In every case, the special education classification was used.

#7: Care Level 4 (n = 107)

Individuals in this group were ranked as having level 4 care needs according to this definition:

Level 4: Generally Independent in Basic Self-Help Skills

a. Toilet trained (few accidents, generally independent)

b. Minimal assistance required with dressing, bathing, eating

c. Staff generally spend a small amount or none of their time in physically assisting the client.

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-19: 3	MDC: 12	Occupational Therapy: 14	Wheelchair: 3
20-29: 46	MSH: 19	Physical Therapy: 1	Alcohol/Drug problem: 3
30-39: 27	EHSC: 6	Speech Therapy: 38	Prader-Willi: 2
40-49: 16	SE: 2	Counseling: 1	Hearing/Visual Impairment: 12
50-59: 9	AC: 66		Autistic/Psychotic: 2
60-69: 4	CFS: 1		
70-79: 2	NH: 1		

Groupings of Unserved/Underserved Children with Developmental Disabilities

#1: Medical Group (n = 4)

Individuals in this group were ranked as having level 1 or level 2 medical needs according to these definitions:

Level 1: Life Support Needs
- a. On site emergency medical help required
- b. Examples: oxygen, suction, medication to terminate seizures

Level 2: Frequent and/or Severe Emergency Medical Needs
- a. Immediate medication adjustment
- b. Seizures, frequent injuries
- c. Requires frequent hospitalization

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-2: 1	EHSC: 1	Occupational Therapy: 4	Gastronomy: 2
3-6: 0	NH: 1	Speech Therapy: 4	Feeding tube: 2
7-12: 0	CFS: 1		Special chair: 3
13-19: 3	SE: 1		Brace/splint 1
			Wheelchair: 3
			Positioning equipment: 1
			Portable suction machine: 1
			Tilt table: 1

#2: Behavior Group 1 (n = 1)

Individuals in this group were ranked as having level 1 behavior problems according to this definition:

Level 1: Behaviorally Dangerous
- a. Intensity of behavior is extremely high and safety of the client, other clients, staff or property is a real issue even with staff present.
- b. Environment must be secure. Access to the community is risky even with staff present.
- c. Need the most sophisticated, well-supervised staff available.
- d. Property damage requires major environmental or staff modification or frequent major repair.

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
13-19: 1	SE: 1	Occupational Therapy: 1	Autistic: 1
		Speech Therapy: 1	Head protective device: 1

#3: Behavior Group 2 (n = 4)

Individuals in this group were ranked as having level 2 behavior problems according to this definition:

Level 2: Serious Behavior Problem

a. Rate and/or intensity is moderately high and constitutes serious management problem.
b. Safety of the client or others generally not an issue with immediate supervision present.
c. An intense staff-to-client ratio will take care of the problem of making the environment secure.
d. Staff well-trained and well-supervised
e. Property damage a significant problem but major environmental modifications not required.

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs:
0-2: 2	MDC: 1	Occupational Therapy: 2	Ambulation aids: 2
3-6: 0	CFS: 2	Speech Therapy: 3	
7-12: 0	SE: 1		
13-19: 2			

#4: Care Group 1 (n = 17)

Individuals in this group were ranked as having level 1 care needs according to this definition:

Level 1: Needs Total Care

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs:
0-2: 4	MDC: 2	Occupational Therapy: 16	Wheelchair: 8
3-6: 1	NH: 7	Speech Therapy: 14	Special chair: 11
7-12: 5	SE: 1		Feeding tube: 1
13-19: 7	CFS: 7		Positioning equipment: 2
			Communication aid: 2
			Special bed: 2
			Belly board: 1
			Head harness: 1
			Ambulation aids: 3

#5: Care Group 2 (n = 7)

Individuals in this group were ranked as having level 2 care needs according to this definition:

Level 2: Extreme deficits in basic self-help skills
- a. Not toilet trained
- b. Few dressing, bathing, eating skills
- c. Considerable staff time required to get through daily routine

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-2: 2	MDC: 1	Occupational Therapy: 5	Wheelchair: 3
3-6: 2	EHSC: 1	Speech Therapy: 5	Communication aid: 1
7-12: 0	SE: 1		Hearing/Visual Impairment: 3
13-19: 3	CFS: 4		Ambulation aid: 5
			Head protective device: 1
			Eating aids: 2
			Therapy ball: 1
			Positioning equipment: 1

#6: Care Group 3 (n = 8)

Individuals in this group were ranked as having level 3 care needs according to this definition:

Level 3: Significant deficits in basic self-help skills
- a. Some assistance required when toileting (prompts)
- b. Requires some assistance in dressing, bathing, eating
- c. Staff must be present to get through daily routine

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-2: 3	CFS: 7	Occupational Therapy: 7	Wheelchair: 2
3-6: 4	SE: 1	Speech Therapy: 7	Special Chair: 1
13-19: 1			Hearing/Visual Impairment: 5
			Ambulation aid: 2
			Prader-Willi: 1

#7: Care Group 4 (n = 22)

Individuals in this group were ranked as having level 4 care needs according to this definition:

Level 4: Generally Independent in Basic Self-Help Skills

a. Toilet trained (few accidents, generally independent)
b. Minimal assistance required with dressing, bathing, eating,
c. Staff generally spend a small amount or none of their time in physically assisting the client.

Other Characteristics:

Age Distribution	Current Location	Specialized Service Needs	Other Needs
0-2: 3	CFS: 11	Occupational Therapy: 2	Wheelchair: 1
3-6: 5	SE: 10	Speech Therapy: 15	Ambulation aids: 2
7-12: 1	EHSC: 1		Hearing/Visual Impairment: 4
13-19: 13			Autistic: 1

Grouping	Children	Adults	Total
Medical 1/2	4	14	18
Behavior 1	1	14	15
Behavior 2	4	59	63
Care 1	17	25	42
Care 2	7	34	41
Care 3	8	38	46
Care 4	22	107	129
	63	291	354

Number of Children and Adults According to Primary Grouping.
(Children: 18 years old or less; Adults: 19 years old or more)

Current Location	Children	Adults	Total
Montana Developmental Center	4	103	107
Eastmont Human Services Center	3	50	53
Child and Family Services Waiting List	32	1	33
Adults: Community Waiting List	0	84	84
Special Education Students: Waiting List	16	10	26
Montana State Hospital	0	39	39
Nursing Home	8	4	12
	63	291	354

Number of Adults and Children According to Current Location.
(Adults: 19 years or older; Children: 18 years or younger)

	MDC	EHSC	MSH	CFS	SE	AC	NH
Medical 1/2	12	2	0	1	1	0	2
Behavior 1	10	0	4	0	1	0	0
Behavior 2	35	9	8	2	2	7	0
Care 1	18	4	2	7	3	0	8
Care 2	11	15	5	4	4	2	0
Care 3	9	16	1	7	3	9	1
Care 4	12	7	19	12	12	66	1
	107	53	39	33	26	84	12

Number of Children and Adults According to Grouping and Current Location
(Children: 18 years or less; Adults: 19 years or more)

Developmental Planning Task Force
Research Sample

Group	Number in Sample	Number in Population	Percent	Multiplying Factor
Eastmont	53	53	100%	1
Montana State Hospital	39	39	100%	1
Nursing Homes (<21)	12	12	100%	1
Montana Dev. Center	107	203	53%	1.9
Waiting List: Adults	84	479*	17%	5.9
Waiting List: CFS	33	255*	13%	7.7
Waiting List: SE	26	199*	13%	7.7
Total	354	1240		

*Most waiting list participants were randomly selected from the December 1985 waiting list. When individuals could not participate in the study (e.g., family moved, no longer on waiting list), new names were randomly selected from the March 1986 waiting list, which had not been available at the time of the initial sampling.

Appendix E: Summary of Children's Needs Assessment

Service Needed	Percent
Skill Acquisition Training	87%
Behavior Management	50%
Parent Training	73%
Constant Supervision	60%
Accessibility	30%
Adaptive Equipment	37%
Diagnosis/Evaluation	87%
Medical Services	37%
Respite	63%

(N = 30)

The children randomly selected from the waiting list for Child and Family Services were included in this assessment. The family trainer most familiar with the child completed the assessment form. Choices for each of the nine items were: (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, (5) strongly agree. Scores of (4) agree or (5) strongly agree were taken as an indication that the child needed a particular service.

Ninety percent of the children were living in their natural homes. Some were already receiving one or more services, with Family Training and Speech Therapy most common (60%). Other services currently received were Special education (57%), Motor Therapy (53%), Respite (50%), Babysitting (27%) and Private Preschool (10%).

January 1987

Tom Crosser
Office of Budget and Program Planning
State Capitol
Helena MT 59601

Dear (IAPF Participant):

As you may know, the Developmental Planning Task Force is a nine-member committee created in March, 1986 by the Developmental Planning and Advisory Council to identify Montanans with developmental disabilities who are unserved or underserved and to determine how best to meet those needs. A secondary mission of the Task Force was to monitor implementation of key recommendations of the HB909 Advisory Council. Five key recommendations were identified by the DDPAC and approved by the Task Force for monitoring. One of those recommendations concerned the need for improved planning, communication, and cooperation between and among agencies through participation in the Interagency Planning Forum (see enclosure).

Through IAPF coordinator, Clyde Muirhead, the Task Force has learned that the forum is a very beneficial mechanism for informal information exchange. On behalf of the Task Force, I applaud your individual and collective efforts to improve service delivery by improved communication.

Sincerely,

Tom Crosser
Chairman
Developmental Planning
Task Force

Enclosure

The "Bluebook": A Report to Governor Ted Schwinden from the House Bill 909 Advisory Council Established Pursuant to Section 2-15-122 MCA, Helena, MT, 1984, Recommendation #12:

The Council recommends, in order to assure free and unrestricted client flow between services, that there be improvements in preplanning, communication, coordination and implementation of client movement between and among educational, residential and other services. This recommendation applies specifically to the Departments of Institutions and Social and Rehabilitation Services and to the Office of Public Instruction as well as to private provider programs. (p. 20)

The "Redbook": A Plan for Services to the Developmentally Disabled Prepared Pursuant to House Bill 909, Office of the Governor, Helena, MT, 1984, Objective 2.3:

Improve pre-planning, communication, coordination and implementation of client movement within the DD service system by June 30, 1986.

Sub-Objective 2.3.1: Representatives of the Office of Public Instruction, the Department of Social and Rehabilitation Services and the Department of Institutions will continue to participate in the activities of the Inter-Agency Planning Forum (IAPF) coordinated by the DD/PAC. (p. 7)

(Rev. 10/82)

STATE OF MONTANA

POSITION DESCRIPTION

Appendix G
DEPARTMENT OF
SOCIAL AND
REHABILITATION SERVICES

A Position Description should be organized into major areas of responsibility with duties detailed under each area. A Position Description should not be a detailed procedures manual or should it paraphrase duty statements from the class specification. As the building block of an effective personnel administration program the Position Description must be completed to assist in classification, pay, recruitment, selection, performance evaluation, training, staffing analysis and other management functions. Thus, in order for this form to be effective, adequate time and effort must be expended in following its instructions, in understanding its intent and in completing it.

The Position Description is to be completed by management. Management must review the Position Description with the employee and furnish the employee with a copy. The Position Description is completed for the position and not the individual employee. Each position must have a Position Description, but it does not need to be redone unless there is a substantial change in duties or you receive a request for an update from Personnel Services. Reclassification requests are to be done according to the SRS Classification Policy.

Before proceeding, PLEASE READ THE ENTIRE FORM to understand how sections relate to each other and to avoid repeating information. If there are any questions about completing this form, contact Personnel Services at 449-3136. Also a Position Description Transmittal (SRS PERS-5) must be completed and submitted with this Position Description.

PLEASE TYPE OR PRINT CLEARLY

1	Classification	Title: APS and DD Worker - Social Worker II	Class Code:	Grade: 12	Position No.:
2	Location	Division:	County or:	District:	
		Bureau or equivalent:	Section or equivalent:	Unit or equivalent:	
		City:	Building & Street:	Room Number:	Business Telephone:
3	Prepared by	Immediate Supervisor's Name and Title:			

Describe the activity, function, product or service of the office or work unit in which the position is situated:

The function of the office is to provide a variety of social services in general and protective services in particular to both children and adults. The office accepts, investigates and resolves as quickly as possible all referrals concerning child or adult abuse or neglect. Other important services pertain to day care, foster care, adoption, the developmentally disabled and elderly clientele.

4 GENERAL SUMMARY OF WORK:

Indicate with a few sentences a general statement of what the position does. This will also be used for recruiting announcements.

This position provides case management services to developmentally disabled adults and children, and protective services to adults who have been or are in danger of being abused, neglected or exploited. An important aspect of this position is working closely with aging services programs to meet the diverse needs of elderly clients. Services to DD clients are based upon a philosophy that seeks to encourage clients' self-sufficiency, maintain and increase independence or, if necessary, arrange for their placement in least restrictive settings. Specific activities include counseling, interviewing, coordinating, assessing, investigating and monitoring implemented strategies. Complete physical records must be kept. Court involvement is likely. Actions are based upon professional judgment, a variety of operational procedures and technical assistance provided by a lead worker, where available, or a supervisor.

DUTIES AND RESPONSIBILITIES OF POSITION:

Describe the duties, tasks and responsibilities of the position beginning with the most important duties. A duty is a large segment or category of work performed and can be used to group related tasks. Task statements are effectively written by using the following format: an action verb, an object, an output and how accomplished. Use language that will enable a person not familiar with the work of the position to understand what is taking place in the work activities described. Avoid words that are not graphic, such as "assists," "develops," "handles," "processes" and "works with." It is important to estimate the approximate percentage of time spent on each duty.

Predominently, this position provides professional social services to adults and children who are developmentally disabled, and, to a lesser extent, protective services to adults who have been abused, neglected or exploited. These services include but are not necessarily limited to investigating complaints, providing competent testimony in court, preparing treatment plans, managing a diverse caseload and coordinating meetings with other professional staff. The person in this position must be able to respond after normal working hours and/or on weekends, and may be required to participate in an on-call system in order to provide emergency protective services by assessing the available information and deciding upon the appropriate action.

INVESTIGATION, PLACEMENT AND CASE MANAGEMENT — 60%

Conducts thorough investigations of cases regarding adult abuse and/or neglect. Investigative approaches include personal contacts by vis a vis or telephone interviewing of referral source, alleged victim, parents, guardian or caretaker; research of agency files; and contact with collateral resources such as schools, mental health, etc. The investigation must result in a determination of the extent to which the report is true, and the subsequent appropriate action.

Must react to referrals by filling out a protective service complaint form using acceptable methods of eliciting information from people in various locations in order to amass all relevant information and determine the proper response.

Coordinates and leads all (initial, semi-annual and emergency) individual habilitation planning meetings for developmentally disabled clients, seeing to completion of necessary forms, approving and subsequently assessing program objectives, and participating in placement planning to ensure the ultimate achievement of the habilitation plan.

May study family foster care homes and the community group care facility for developmentally disabled or adults by personal visitation to see if current standards are being met in order to recommend for licensing.

Provides emergency child protective services when on call by recording all relevant information on a protective services complaint form in order to correctly assess the immediate circumstances and determine the appropriate response.

Acts as case manager for developmentally disabled adults and children who need no or minor protective services. Duties include indentification, documentation and assignment of priority to the social, emotional, cognitive and physical needs of the clients; development of functional activities, tasks and objectives for the clients; documentation of delivered and undelivered services; advocacy of the clients' needs, rights and overall well-being; and follow up planning for the clients' future goals.

COURT-RELATED DUTIES — 15%

Must respond to court orders by preparing written court reports which may include background information pertaining to placement, financial affidavits, medical authorizations, social study conclusions and final recommendations for the most appropriate services to clients in order for the court to make critical judicial decisions.

(Continued on attached page)

(Attach additional sheets if necessary)

DUTIES AND RESPONSIBILITIES, CONTINUED:

Prepares adults for court appearances by familiarizing them with court proceedings through role play, visiting the court environment, meeting legal professionals and discussing the question/answer format. This orientation facilitates the client's participation which, in turn, helps the court make the best possible determination for appropriate social services.

Assumes role as primary or secondary resource in guardianship cases. May assist client or court-appointed guardian in financial dealings, property disbursement, medical care, SSI, social security program and record-keeping.

Helps clients prepare for SSI appeal process by preparing written reports which identify clients' functional ability, medical status and social skills, by arranging for clients' legal assistance and by attending hearing. Hoped for result is SSI eligibility.

Adopts role of amicus curiae when required by the court to verbally present background information, relevant evidence or informed advice in order to protect a clients' legal rights.

CONTACT WITH OTHER AGENCIES AND PEOPLE 15%

Provides specific written and/or verbal instructions to homemakers, personal care attendants or case aides to ensure that their interactions with clients promote and ultimately achieve the specific objectives in the written case plan.

Makes informative presentations concerning the nature and provision of social services at meetings, workshops or seminars through verbal and written means in order to foster and enhance community education and to develop additional local resources.

Arranges for necessary medical attention, financial assistance and other supportive services for adults and children by completing all required forms, making appropriate referrals and scheduling appointments in order to ensure the greatest possible degree of clients' self-sufficiency and protection from harm.

Provides services to adult clients in nursing homes by coordinating medical and financial needs and participating in discharge and placement planning in order to ensure that clients approach a realistic degree of self-sufficiency and independence.

Coordinates local service agencies and specialized service groups, such as resource and planning teams, by means of direct contact in order to ensure the provision of the most appropriate services using an interdisciplinary approach.

CASE RECORD MAINTENANCE 10%

Must devise own or assess others' written treatment plan, taking into consideration all pertinent information gathered from referral source, client and others involved. In addition to containing other information, the treatment plan must address a clearly identified problem, set specific goals, discuss agency involvement and the nature and length of services needed in order to successfully resolve the problem.

Maintains all case records by filing relevant information, both initial and current, in prescribed category and order in accordance with CSD case record management policy.

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PERSONAL CONTACTS, CONTINUED:

Developmental Disability Staff, weekly/daily, within agency - to provide and solicit information, consultation and coordination of services.

(Continued on next sheet)

PERSONAL CONTACTS, CONTINUED:

County Attorney/Law Enforcement Officials, frequently, external - to receive legal guidance.

Client contacts, daily, external - to elicit and disseminate relevant information, and arrange for services or further referral.

General Public, occasionally, external - to disseminate information explaining social service programs and policies, and alternative resources.

SUPERVISION RECEIVED, CONTINUED:

Service guidelines are provided by State statutes, CSD Policy and Procedures Manuals, and central, district and county office directives. The Social Worker Supervisor completes a performance appraisal annually to assess past performance and establish new goals and objectives.

6 SUPERVISION EXERCISED: List the position number and title of positions directly supervised. Direct supervision involves assigning, directing and reviewing an employee's work and includes completing the employee's performance appraisal.

Position No.	Title	Position No.	Title

7 EQUIPMENT OR MACHINERY USED: Indicate the percent of total work time.

Type	%	Type	%

8 PERSONAL CONTACTS:

Describe the types, reasons for and frequency of major personal contacts necessary to perform the work of this position. Indicate whether contacts are within work unit, within agency or external.

Supervisor contacts, weekly/daily within work unit - to receive work assignments, exchange information and do case consultation.

Lead Worker (where available), frequently, within work unit - to exchange information and receive technical assistance.

Clerical contacts, daily, within work unit - to provide information for documentation and make arrangements for case records maintenance and correspondence.

Economic Assistance Staff, weekly, within agency - to acquire eligibility information regarding clientele.

Social Work Staff, daily, within work unit and agency - to seek and provide information, consultation and technical assistance.

Continued on previous attached sheet.

9 DECISIONS AND COMMITMENTS: SCOPE AND EFFECT

Describe areas, kinds and impact of decisions and commitments; the effects, influence and significance of the work of the position; the consequency of error and subsequent accountability, and limitations on the extent and finality of actions and decisions.

This position often requires decisions that can have critical consequences. Judgments must be made concerning whether or not to remove clients from abusive environments, as well as whether or not to return clients to potentially harmful environments. Deciding whether or not to seek court action is another serious phase of this position. Approval of suggested programs for and placement of DD clients is an important responsibility. Errors in judgment can result in physical and/or emotional harm to clients, or even injury or death. There is a possibility of liability issues which could result in lawsuits.

10 SUPERVISION RECEIVED:

Describe how this position is supervised by using the following as a guide:
1. How is work assigned, i.e., in what format, by whom, etc.? 2. How are work methods, procedures and priorities determined? 3. What guidelines, manuals, procedures & references are available & how are they used? 4. What assistance is available from others, i.e., supervisor, coworkers, outside specialists, etc.? 5. How is work reviewed, i.e., by whom, how often, by task, by objective, what methods, etc.?

Workload is assigned by the Social Worker Supervisor according to agency policy and established criteria. While encouraging the worker to take the initiative and to make independent judgments, at the same time, the supervisor frequently consults with the worker concerning case problems and acceptable solutions. When needed or desired, technical assistance and consultation is available from the lead worker, SSA II, SSA III, the County Director, DD staff, CSD Program Officers and Management Operations Bureau.

Continued on previous attached sheet.

11 KNOWLEDGES, SKILLS AND ABILITIES:

Describe the knowledges, skills and abilities (KSA's) that are specifically job related, essential to perform the work of this position and are essential for appointment to this position. Do not include those things typically learned on the job. These are to be consistent with the KSA's used for recruitment. Use the class specification as a guide.

Must have CONSIDERABLE:

Knowledge of and skill working within the branch of Montana's legal system pertaining to adult protective services.

Knowledge of family dynamics and skill in assessing levels of stress and degrees of tolerance within the family unit.

Skill in presenting relevant testimony or acting as client advocate in court case concerning protective services for adults.

Skill in interviewing adults and others involved in cases of abuse and/or neglect.

Knowledge of personality development theory and age-appropriate behavior.

Knowledge of casework management techniques including risk assessment, problem identification, family assessment, treatment plans and monitoring.

Continued on attached sheet.

12 EDUCATION AND EXPERIENCE:

Describe specific kind, amount and level of education (curriculum, courses, specialization) and experience that indicate the source of KSA's and that can be used in selecting a person for this position. These are to be consistent with the education and experience requirement used for recruitment. Use the class specification as a guide.

Bachelor's degree in Social Work or a related human services discipline and at least one year of experience in the field of social work, or Master's degree in Social Work or a related human services discipline.

13 PHYSICAL DEMANDS AND WORKING CONDITIONS:

Describe any physical demands, working conditions or job hazards that affect how the incumbent performs the job or that impose additional requirements in selecting a person for the position or that affect the complexity and nature of work. Indicate if travel is required and estimate percentage of time. This position requires a person who can cope with a high level of stress & anxiety when such situations arise. All cases have the potential for disastrous outcomes, even routine ones; and routine cases can become, at times, unforeseeably complicated. In addition to some emotional duress, there are various physical demands such as lifting and carrying clients, climbing over obstacles in cluttered homes, exposure to communicable diseases and unsanitary conditions, and possible contact with hostile or violent clients or others IMMEDIATE involved. Travel is approximately 20% of the time. Must have own car.

14 SUPERVISOR'S SIGNATURE: _____

15 ADMINISTRATIVE REVIEW AND APPROVAL:

1.

Signature: _____ Title: _____ Date: _____

2.

Signature: _____ Title: _____ Date: _____

3.

Chief Personnel Officer: _____ Date: _____

KNOWLEDGES, SKILLS AND ABILITIES, Continued:

Must have CONSIDERABLE:

Knowledge of community resource development, utilization and coordination.

Knowledge of counseling techniques pertinent to protective services.

Skill in visually detecting and assessing physical or emotional abuse or neglect.

Knowledge of appropriate intervention, treatment and placement methods appropriate to protective services for cases that are mostly routine.

Skill in working with developmentally disabled children and adults, assessing their needs and coordinating the provision of specialized services.

Ability to communicate effectively verbally and in writing.

References

Professional Literature

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